Trust Board paper R1

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 7 September 2017

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Col (Ret'd) Ian Crowe, Non-Executive Director

DATE OF COMMITTEE MEETING: 27 July 2017

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE PUBLIC TRUST BOARD:

- **NURSING AND MIDWIFERY QUALITY AND SAFE STAFFING REPORT – MAY 2017**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR THE INFORMATION OF THE PUBLIC TRUST BOARD:

None

DATE OF NEXT COMMITTEE MEETING: 31 August 2017

Col (Ret'd) Ian Crowe – Committee Chair and Non-Executive Director

Paper A1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
MINUTES OF A JOINT MEETING OF THE INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE AND THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 27 JULY 2017 AT 12.30PM TO 1.00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Mr J Adler – Chief Executive
Col. (Ret'd) I Crowe – Non-Executive Director (Chair)
Mr A Furlong – Medical Director
Mr A Johnson - Non-Executive Director
Mr R Moore - Non-Executive Director
Mr B Patel – Non-Executive Director
Ms L Tibbert – Director of Workforce and Organisational Development
Ms C West, Director of Nursing and Quality, Leicester City CCG

In Attendance:
Mr S Barton – Director of Operational Improvement
Mr C Benham - Director of Operational Finance
Miss M Durbridge – Director of Safety and Risk
Mrs S Everatt – Interim Trust Administrator
Mr D Kerr – Director of Estates and Facilities
Mr T Lynch – Interim Chief Operating Officer
Ms E Meldrum – Acting Deputy Chief Nurse
Ms K Rayns – Trust Administrator

RESOLVED ITEMS

42/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr K Singh – Chairman; Ms M Gordon – Patient Partner (IFPIC); Mr W Monaghan – Director of Performance and Information; Ms J Smith, Chief Nurse; Mr P Traynor – Chief Financial Officer; Mr M Caple – Patient Partner (QAC), and Mr M Traynor – Non-Executive Director (IFPIC Chair).

43/17 JOINT DISCUSSION ON QUALITY AND OPERATIONAL PERFORMANCE

43/17/1 Month 3 Quality and Performance Report

Members of IFPIC and the Quality Assurance Committee (QAC) held their third joint monthly meeting to consider the issues covered within the month 3 Quality and Performance report (circulated as Joint Paper 1). Executive Directors particularly highlighted the following issues:-

(a) continued strong performance against the RTT 18 weeks standard (92.3% against the 92% target). However, a downturn in performance was expected in July 2017 due to the high numbers of referrals and reduced clinical capacity due to staff annual leave;
(b) cancelled operations continued to be non-compliant (1.01% against the target of 0.8%) due to emergency pressures and there were 10 patients in June 2017 who were not re-booked within the 28 day standard;
(c) 6 week wait diagnostics performance stood at 0.7% (against the 1% national target), representing 9 consecutive months of strong performance;
(d) 62 day cancer performance had deteriorated to 76.6% (against the 85% target) as a result of services treating their backlog patients. The Chief Executive briefed

members on a training issue within Gynaecology which had led to a change in 1 procedure. The service had been tasked with developing plans to mitigate the position within the next 2 weeks;

(e) UHL's Summary Hospital-level Mortality Indicator (SHMI) for January 2016 to December 2016 had reduced to 101 and remained within the expected range. A report on 2 recently received mortality outlier alerts would be provided to the 31 August 2017 QAC meeting; **MD**

(f) in-month fractured neck of femur performance was compliant for the second consecutive month (76.8% of patients had received their surgery within 35 hours of admission). However, the cumulative year-to-date performance remained below the target (at 66.8%) due to the poor performance in April 2017. A report on fractured neck of femur performance also featured on the 27 July 2017 QAC agenda;

(g) the action plans to respond to 3 Never Events were scheduled for QAC consideration in August 2017; **MD**

(h) there had been 5 avoidable pressure ulcers (grade 3) in June 2017 and arrangements were underway to triangulate these cases against the ward level and staffing data to confirm whether there was any common theme. An update on the outcome of this review would be presented to the 31 August 2017 QAC meeting; **ADCN**

(i) Estates and Facilities performance trends had improved in June 2017 for cleanliness, patient catering and portering, following a dip in May 2017. There had been no Datix incident reports for late or incorrect patient meals and the patient catering satisfaction scores were very positive, and

(j) the results of the recent PLACE (Patient Led Audit of the Care Environment) inspections were expected to demonstrate a step change in performance and UHL was hoping to be rated as one of the most improved Trusts in this respect. A report on the formal results would be presented to the September 2017 QAC meeting. **DEF**

In discussion on Joint Paper 1, the following comments and queries were noted:-

(i) Colonel I Crowe, Non-Executive Director noted the good news that the formal data on delayed transfers of care remained within the tolerance, but he requested additional information about the range of other delays which did not appear in the statistics. It was agreed that an update on the new Integrated Discharge Team (IDT) would be provided to the 31 August 2017 meeting; **ICOO**

(ii) the Medical Director briefed the Committee on the work being undertaken to reduce emergency readmissions, providing assurance that the Red to Green processes were embedded in the discharge planning. The dedicated resource that was previously targeted towards patients at high risk of readmission had been absorbed into the Integrated Discharge Team (IDT) and this aspect was being built into the IDT role and standard operating procedures accordingly;

(iii) Mr A Johnson, Non-Executive Director queried whether emergency readmissions solely related to patients being readmitted with the same condition, noting in response that the data captured all patients readmitted within 30 days, irrespective of their presenting condition. Patients with multiple complex conditions were usually provided with a specific care plan and wrap around GP support to avoid repeated admissions;

(iv) Mr B Patel, Non-Executive Director and Acting Chair noted that some readmissions took place because the patient's first contact was not satisfactory and they were seeking additional assurance. He highlighted the importance of staff spending sufficient time in applying the PARR30 score to such patients and ensuring that the correct processes were followed, and

(v) Mr A Johnson, Non-Executive Director noted an increasing trend in positive reportable Clostridium Difficile cases (10 in June 2017 compared to none in May 2017). As no link had been established by time and place of infection, he queried whether any other factors had affected the data, such as a change in hand sanitiser or a change in cleaning practices. In response, the Director of Estates and Facilities

advised that no such changes had been made and there was no established link to the physical environment. The Medical Director advised that antibiotic prescribing and hand hygiene were also key factors in this respect. The Acting Deputy Chief Nurse agreed to seek further details on this issue and present an update to the 31 August 2017 meeting. **ADCN**

Resolved – that (A) the contents of the Quality and Performance Report (circulated as Joint Report 1) be received and noted;

(B) an update on the new Integrated Discharge Team processes and the range of other factors that were currently causing delayed discharges be presented to the joint IFPIC/QAC meeting on 31 August 2017; **ICOO**

(C) additional information relating to the June 2017 rise in positive reportable Clostridium Difficile (CDT) results be provided to the QAC meeting on 31 August 2017; **ADCN**

(D) briefings on 2 Mortality Outlier Alerts to be provided to QAC on 31 August 2017; **MD**

(E) the action plans to respond to 3 Never Events in May 2017 to be submitted to the August 2017 QAC meeting; **MD**

(F) the Acting Deputy Chief Nurse be requested to review the level 3 pressure ulcers data (5 reported in June 2017) and triangulate this information with the ward staffing levels to establish whether there were any links, and **ADCN**

(G) a report on the PLACE results be scheduled on the QAC agenda for September 2017. **DEF**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
MINUTES OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 27 JULY 2017 AT 1.00PM TO 4.00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Mr J Adler – Chief Executive
Col. (Ret'd) I Crowe – Non-Executive Director (Chair)
Mr A Furlong – Medical Director
Ms S Hotson – Director
Mr A Johnson - Non-Executive Director
Mr R Moore - Non-Executive Director
Mr B Patel – Non-Executive Director
Ms C West, Director of Nursing and Quality, Leicester City CCG

In Attendance:
Mr A Currie - Clinical Director, MSS (for Minute Reference 46/17/1)
Miss M Durbridge – Director of Safety and Risk
Mrs S Everatt – Interim Trust Administrator
Ms E Meldrum – Acting Deputy Chief Nurse
Mr M Nattrass – Head of Operations, CHUGGS (for Minute Reference 46/17/2)

RECOMMENDED ITEMS

44/17 NURSING AND MIDWIFERY QUALITY AND SAFE STAFFING REPORT – MAY 2017

The Acting Deputy Chief Nurse presented paper F which detailed triangulated information (using both hard and soft intelligence) relating to nursing and midwifery quality of care and safe staffing. This information provided an overview of patient areas to highlight where improvement was required and also to highlight areas of high performance. No wards had triggered as a Level 3 concern, 9 wards had triggered as a Level 2 concern and 19 wards had triggered as a Level 1 concern. Two wards, one at LRI and one at LGH, triggered as causing particular concern to the Chief Nurse and Corporate Nursing Team, one of which was due to challenges with nurse staffing vacancies. In discussion, assurances were sought (and received) that both wards were being supported to progress the issues. A discussion took place around the current challenges with nurse staffing over the summer period and plans to address this, along with use of the Safe Care Tool for ward staffing and consideration of a broader role for the ward clerk. In discussion of the current challenges with nurse staffing it was agreed that the Trust Board would be alerted to these concerns. **Cttee Chair**

Registered nurse vacancies had decreased in the Trust in month from 505 whole time equivalents to 486 whole time equivalents, although this had risen in recent weeks. A small number of overseas nurses had commenced in post, although this continued to be challenging due to national IELTS requirements which had been reported in the national media recently. The NMC had reported that for the first time in its history, there were more nurses leaving the register than entering on it. Models continued to be developed at a local level to explore alternative skill mixes for ward teams. Health Care Assistant recruitment continued to be successful and were proving to be high quality applicants. A recent housekeeper recruitment day had attracted 110 attendees. Following shortlisting and interviews, 35 housekeepers would commence induction to the Trust in September 2017.

It was noted that the Care Quality Commission (CQC) had recently undertaken an unannounced inspection of wards 42 and 43. No significant issues had been identified at the time of the visit but further information had been requested, with a CQC report anticipated in August 2017. An action plan would be shared at EQB and QAC in August 2017. In addition to the visit, there had been a whistleblowing enquiry received from the CQC and a response was due back to them on 28 July 2017. It was agreed that the response would be circulated by the Director of Clinical Quality to QAC members following sign off by the Acting Deputy Chief Nurse. As ward 22 at LRI had been deemed as a ward of concern for some time it was agreed that an item would be added to the upcoming EQB agenda for discussion on this matter. **DCQ** **DCQ** **ICCSO**

<u>Recommended</u> – that (A) the contents of paper F be received and noted;

(B) that the Trust Board's attention be alerted to the current challenges with regards to nurse staffing. **Cttee Chair**

(C) that an action plan be shared at the August 2017 EQB and QAC in response to the recent unannounced CQC visit to wards 42 and 43; **DCQ**

(D) that the CQC whistleblowing response be circulated to QAC members including CCG representatives once it has been signed off by the Acting Deputy Chief Nurse, and **DQQ**

(E) to include as a 'Hot Operational Issue' on the August 2017 EQB agenda an item for the Chief Executive to provide a verbal update on 'Actions to Support Ward 22 at LRI' **ICCSO**

RESOLVED ITEMS

45/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr K Singh – Chairman; Mr W Monaghan - Director of Performance and Information; Ms J Smith, Chief Nurse; Mr P Traynor - Chief Financial Officer; Mr M Caple – Patient Partner (QAC), and Mr M Traynor - Non-Executive Director.

46/17 MINUTES

Resolved – that the Minutes of the meeting held on 29 June 2017 (paper A1 refers) be confirmed as a true and accurate record.

47/17 MATTERS ARISING

Paper B detailed both the actions from the most recent meeting, and also any which remained outstanding from previous QAC meetings. The Chair noted that good progress continued to be made in progressing actions. No further updates were required for the entries on the Matters Arising log.

Resolved – that the contents of paper B be received and noted.

47/17/1 Fractured Neck of Femur performance – update report

Papers C, as presented by the Clinical Director, MSS, provided a progress update against the locally agreed 72% threshold for time to theatre within 36 hours for patients with a hip fracture (fractured neck of femur). It was noted that performance remained variable with 71.2% in March 2017, 46% in April 2017, 76.5% in May 2017 and 77.6% in June 2017. A number of processes have been put in place to improve performance including a bleep system in the Emergency Department for fractured neck of femur patients. Theatre utilisation continued to be monitored and all day lists had been put in place. A Deputy Clinical Director had been appointed to work with the Trauma and Orthopaedics team to make further improvements to performance and working practices. It was confirmed that whilst changing working practices would almost achieve the target, further resources would be required longer term to sustain performance whilst remaining within the financial envelope available.

The QAC was specifically requested to note progress to date and to provide feedback as to whether the committee felt that all appropriate actions had been undertaken. In discussion of this item, it was agreed that a paper would be provided to the QAC in 3 months' time and thereafter quarterly. The paper would include a plan on how to reduce variation between months to improve performance. **CD, MSS**

Resolved – that (A) the contents of paper C be received and noted, and

(B) that an update paper be provided to QAC in 3 months' time and thereafter quarterly. To include within the paper a plan on how to reduce variation **CD, MSS**

between months to improve performance.

47/17/2 Haemoglobinopathy Service update (ESB Matters Arising 3.2.3 of 13.6.17)

The Head of Operations, CHUGGS presented paper D which detailed service provision for the Haemoglobinopathy service. The Trust was currently commissioned by NHS England as a Specialist Haemoglobinopathy Centre for diseases of the red blood cells such as Sickle Cell Disease and Thalassaemia for adults and children living in Leicestershire, Northamptonshire and Rutland. The service had been operated as a single consultant service but following retirement there had been difficulties in securing a replacement clinician and the Head of Service for Haematology had subsumed the role in the short-term. Backfill arrangements for her bone marrow transplant work were being established. The paper (and discussions) provided assurances that requirements to ensure the safety of patients going forward and clinics to conduct an annual review of patients were underway. Commissioners have been updated and a plan would be developed over the coming months, with network discussions planned for September 2017.

The QAC was specifically requested to review the report and be assured that the CMG was undertaking the correct actions to ensure that the service was being provided in a safe manner to patients. In discussion of this item, it was agreed that an updated report would be provided to QAC in 3 months' time which detailed progress made and a planned approach for the future of the service and whether the service should continue to operate as a comprehensive centre. The Director of Safety and Risk would also build in any intelligence on harm reviews. **HoO, CHUGGS**

Resolved – that (A) the contents of paper D be received and noted, and

(B) that an updated report be provided to QAC in 3 months' time which detailed progress made and a planned approach for the future of the service and whether the service should continue to operate as a comprehensive centre. **HoO, CHUGGS**

48/17 COMPLIANCE

48/17/1 Assurance Report for EWS and Sepsis

The Medical Director presented paper E, providing the Committee with an update on the work programme being undertaken to improve the care of patients with a deteriorating Early Warning Score (EWS) and Red Flag Sepsis trust-wide. The Emergency Department continued to perform well against the indicators with patients screened for sepsis and IV antibiotics indicators performing particularly well during the period. The Sepsis 6 Bundle as a whole was being achieved. Inpatient indicators continued to represent a challenge although improvement had been seen in the last two weeks of reporting which correlated with the relaunch of the sepsis pathway. It was anticipated that automated reporting was almost available for EWS but would be a longer time period for Sepsis. No harm had been identified during the time period for patients who had in excess of a three hour delay in receiving IV antibiotics.

The QAC was specifically requested to: (1) be advised that significant work had been undertaken to recognise and respond to the deteriorating patient and management of patients, and (2) advise on any required changes to the format of the report.

Resolved – that the contents of paper E be received and noted.

49/17 QUALITY

49/17/1 Data Quality and Clinical Coding

In the absence of the Director of Performance and Information the quarterly update report was received and noted. The team were commended on the addition of an apprentice coding trainer.

Resolved – that the contents of paper G be received and noted.

49/17/2 LLR Quality Clinical Audit update July 2017

The Medical Director presented paper H which detailed that following the Learning Lessons to Improve Care review (LLtIC review) undertaken in 2012/13 and published in 2014 in response to concerns around fragmentation of care across the LLR health system, in line with the report findings in 2014 there had been a system commitment to carry out a further LLR Clinical Quality Audit. The paper outlined how this re-audit would be undertaken and the revised scope of the audit. The anticipated timescale for reporting of the audit findings would be January/February 2018. An information governance issue around data transfer with GP practices was currently being worked through with NHSE. The QAC was specifically requested to note the report and advise of any further actions to be taken. An updated report would be provided at the November 2017 QAC meeting. **MD**

Resolved – that (A) the contents of paper H be received and noted, and

(B) that an update be provided at the November 2017 QAC meeting. **MD**

50/17 SAFETY

50/17/1 Report from the Director of Safety and Risk including (1) Patient Safety Report – June 2017, and (2) Complaints Performance Report – June 2017

The Director of Safety and Risk presented paper I which was comprised of two sections: (1) patient safety, and (2) complaints performance. The patient safety report provided the patient safety data for June 2017 and noted that two Serious Incidents had occurred during June 2017, both related to failure to follow up. A Regulation 28 Letter had been received and it was agreed that the letter and response would be shared at the August 2017 EQB and QAC. It was noted that there had been a disappointing reduction in reported patient safety incidents in three Clinical Management Groups. There continued to be 100% CAS compliance and no alerts had breached their deadline during the reporting period. Patient Safety comparators with peers would be provided in the report in August 2017 for EQB and QAC. **MD**

The report noted that there had been a decrease in complaints activity during the month, along with an 18% decrease overall in PILS activity. Resolution of complaints was largely positive but remained challenging in ESM due to the Emergency Department. No new PHSO cases had been received or closed. A missed deadline review capture tool had been created within Datix for complaints that missed their deadline.

In addition to the reports, three issues were highlighted for the attention of QAC members – (1) 2016/17 Serious Incident themes, actions and improvement (provided a review of Serious Incidents reported within the Trust in 2016/17. The actions for improvement were identified, together with the links to the relevant elements in the 2017/18 Quality Commitment. It was agreed that the Serious Incident Themes 2016/17 contained in Appendix A of the report should be included in the September Chief Executives Briefing. In discussion of this item it was noted that the Rejected Imaging Working Group was working well. Analysis of last years data shows a further 41% reduction in avoidable death and harm from the previous year.); (2) Safer Surgery (an internal Safety Summit had been convened by the Medical Director and Chief Nurse following three Never Events in May 2017 had identified the need for a relaunch of 'Safer Surgery', and this had been reviewed at the Policy and Guidelines Committee in July 2017.), and (3) IRMER incidents in quarter 1 (only one incident had occurred in quarter one showing a marked reduction from 2016/17. The CQC radiation protection visit had been well received). **DDC**

Resolved – that (A) the contents of paper I be received and noted;

(B) that the most recent Regulation 28 letter and response be provided to the August 2017 EQB and QAC meetings, and **MD**

(C) to include a copy of the Serious Incident Themes 2016/17 (Appendix A of the report) in the next Chief Executives Briefing. **DDC**

50/17/2 NHS Litigation Authority – final report

The Director of Safety and Risk presented paper J which detailed how the NHSLA bid monies of almost £1.6m had been spent. The paper would be required for onward circulation to the NHSLA (now known as the NHS Resolution). The contents of the report were agreed by the committee for onward circulation. **All**

Resolved – that (A) the contents of paper J be received and noted, and

(B) that the contents of the report be agreed prior to wider circulation. **All**

50/17/3 Life QI Demonstration

The Director of Safety and Risk provided a presentation of the Life QI system which staff can register on free of charge. The system enables staff to share their QI projects within their Trust and across organisations, if desired. The Director of Safety and Risk encouraged members to register and use the system. In discussion of this item the Director of Safety and Risk provided the link to the system for Corporate and Committee Services to circulate. It was agreed that to avoid any duplication with internal project systems that the Director of Safety and Risk would speak to the Senior OD and Improvement Manager around the UHL system. **ICCSO** **DSR**

Resolved – that (A) the contents of the demonstration be received and noted;

(B) that the web address for the system be circulated to QAC members, and **ICCSO**

(C) to discuss with Steve Gulliver (Senior OD and Improvement Manager) outwith the meeting with regards to any potential duplication from use of the Life QI and internal UHL systems. **DSR**

51/17 PATIENT EXPERIENCE

51/17/1 Triangulation of Patient Feedback – quarter 4 2016/17

The Acting Deputy Chief Nurse presented paper K which provided a quarterly triangulation report based on patient feedback. Waiting times and outpatients were identified as the main themes. The QAC were specifically asked to: (1) receive and note the report, and (2) support the advancement of the triangulation of feedback by receiving a quarterly report. It was noted that a significant amount of work went into producing the report and that consideration should be given to providing a more summarised report. **CN/ADCN**

Resolved – that (A) the contents of paper K be received and noted, and

(B) that the Chief Nurse and Acting Deputy Chief Nurse review outwith the meeting the information provided in this report and whether a more summarised report can be provided. **CN/ADCN**

52/17 ITEMS FOR INFORMATION

52/17/1 No items were noted for information.

53/17 MINUTES FOR INFORMATION

53/17/1 Executive Quality Board

Resolved – that the notes of the meeting of the Executive Quality Board held on 4 July 2017 (paper L refers) be received and noted.

53/17/2 Executive Performance Board

Resolved – that the notes of the meeting of the Executive Performance Board held on 27 June 2017 (paper M refers) be received and noted.

53/17/3 QAC Calendar of Business

Resolved – that the QAC Calendar of Business (paper N refers) be received and noted.

54/17 ANY OTHER BUSINESS

54/17/1 None noted.

55/17 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that a summary of the business considered at this meeting be presented to the Trust Board meeting on 3 August 2017, and one item around nurse staffing (detailed in Minute Reference 44/17) was noted as needing to be brought to the attention of the Trust Board. **Cttee Chair**

55/17 DATE OF NEXT MEETING

<u>Resolved</u> – that the next meeting of the Quality Assurance Committee be held on Thursday 31 August 2017 from 1.30pm until 4.00pm in the Board Room, Victoria Building, Leicester Royal Infirmary.

<u>The meeting closed at 3.17pm.</u>

Sarah Everatt
Interim Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2017-18 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	4	4	100	*R Moore*	4	0	0
S Crawshaw (until May 2017)	2	2	100	*B Patel*	4	4	100
I Crowe (current Chair)	4	3	75	*K Singh*	4	3	75
A Furlong	4	4	100	*J Smith*	4	2	50
A Goodall	4	0	0	*M Traynor*	4	3	75
A Johnson	4	3	75	*C West – Leicester City CCG*	4	2	50
K Kingsley – Leicester City CCG	4	0	0				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	4	3	75	*D Leese – Leicester City CCG*	4	0	0
M Durbridge	4	3	75	*C Ribbins/E Meldrum*	4	3	75
S Hotson	4	3	75	*L Tibbert*	4	0	0